

# CASEREVIEW

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## Notice of Independent Review Decision

**DATE OF REVIEW:** March 22, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Individual Psychotherapy x 6 sessions over 3 months (90806)

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This is a Board Certified Psychologist with over 24 years of experience.

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

01/09/12: Progress Note (Handwritten, author unknown)  
01/10/12: Patient Notes by (Handwritten)  
01/23/12: Chronic Pain Management Program Discharge Summary by  
01/25/12: Follow-up Evaluation by  
02/13/12: UR performed by  
02/24/12: Response to Denial Letter by  
03/02/12: UR performed by

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his back while lifting on xx/xx/xx. On February 20, 2011, he underwent L5/S1 fusion by. Following surgery, he continued to have intermittent back pain and took Hydrocodone.

On January 9, 2012, there is a handwritten progress note by an unknown author that reported the claimant was doing well on Citalopram 20 mg. He reported decrease in depression and no more anxiety. Assessment: Patient is really in full remission from the depression and anxiety with prescription. Plan: Continue Citalopram 20 mg.

On January 10, 2012, the claimant was evaluated by who reported he had some radicular pain bilaterally and intermittently. He did not walk with a limp. She reported he was not working and was drawing TIBS. Medications were refilled.

On January 23, 2012, the claimant was discharged from a 20 day Chronic Pain Management Program at Diagnosis and/or Related Symptom(s)/Problem(s): Adjustment disorder, with mixed anxiety and depressed mood; pain disorder associated with both psychological factors and a general medical condition; occupation problem; lumbar sprain/strain; displacement of thoracic or lumbar intervertebral disc without myelopathy; injury related psychosocial stressors; and global assessment of functioning deficits. It was noted that the claimant maintained good attendance, remained compliant and motivated throughout treatment. It was reported he took Norco for pain and Celexa for depression. It was reported after participating in 20 days of CPMP, the claimant scored a 15 on Physical Subscale (decreased by 4 points) and a 28 on Work Subscale (decreased by 7 points) on the Fear-Avoidance Beliefs Questionnaire. On the Pain Experience Scale, he scored a 43, which was decreased by 8 points. On the McGill Pain Questionnaire, he scored a 34, which was decreased by 5 points. On the Revised Oswestry Low Back Pain Disability Questionnaire, he scored at a 35% slightly down from the prior score of 40%. He continued to report problems with pain intensity. On Beck Depression Inventory he scored a 13. This score had remained stable during his treatment. On Beck Anxiety Inventory he scored a 21 which was decrease by 4 points from prior score of 25. It was indicated that during the last treatment phase, the claimant improved significantly on his affective and physical functioning. Treatment was being requested for the claimant to participate in 6 sessions of individual psychotherapy, 2 sessions a month over three months, due to ongoing physical complaints. felt the claimant would benefit from continued care to address his affective feelings and cognitive issues related to his current physical condition. Discharge plan: Home exercise program, follow-up limited diagnostic psychological evaluation to monitor symptom progress and the patient's responsiveness to treatment planned and requested.

On January 25, 2012, the claimant had a follow-up evaluation with who reported his pain to be a 1 ½ to 3 ½ /10. It was reported the claimant felt the CPMP was very helpful and he felt like his ability to cope with daily living activities was greater. He felt the need for medication had reduced proportionately to his reduction in pain and his increase in coping skills. In addition, heat packs, stretching exercise, range of motion exercises and massage helped decrease the pain and discomfort. Plan: maintain modified work status for 60 days, continue medication management per MD, and continue with home exercise program.

On February 13, 2012, performed a UR on the claimant. Rationale for Denial: The patient completed a CPMP 20 sessions. Clinical notes indicate the patient also had individual psychotherapy of 6 sessions prior to the CPMP, clinical documentation provided of the psychotherapy sessions was not submitted for review. The physician notes in the patient's discharge summary report from the CPMP note that the patient has had minimal declines in his test scores for psychological testing after completing the CPMP & after psychotherapy sessions of 6 to date. Guidelines indicate, with evidence of objective functional improvement, psychotherapy can continue. The documentation provided lacked evidence to support the current request for additional psychotherapy sessions for this patient.

On March 2, 2012, performed a UR on the claimant. Rationale for Denial: This claimant completed 20 sessions of a chronic pain management program (CPMP) and made very little psyche progress. Additional sessions are not warranted without extenuating circumstances and as there was no return call from the provided, this could not be established.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The previous adverse determinations are upheld. Both correctly came to the conclusion that after 6 individual sessions and 20 CPMP sessions, the records indicates little to no progress psychologically. ODG guidelines indicate only with "evidence of objective functional improvement" can individual therapy be continued. Furthermore, indicated on multiple occasions that felt the claimant would benefit from continued care to address his affective feelings and cognitive issues related to his current physical condition. However, on January 25, 2012, only indicated in his plan of treatment that the claimant would maintain modified work status for 60 days, continue medication management per MD, and continue with home exercise program. never mentioned the need for continued psychotherapy sessions. Therefore, I uphold the denial of the requested Individual Psychotherapy x 6 sessions over 3 months (90806).

**ODG:**

Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the [Pain Chapter](#)). Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. ([Newton-John, 1995](#)) ([Hasenbring, 1999](#)) ([van Tulder-Cochrane, 2001](#)) ([Ostelo-Cochrane, 2005](#)) ([Airaksinen, 2006](#)) ([Linton, 2006](#)) ([Kaapa, 2006](#)) ([Jellema, 2006](#)) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. ([Keller, 2004](#)) ([Storheim, 2003](#)) ([Schonstein, 2003](#)) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate on this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). ([Lang, 2003](#)) A recent RCT concluded that lumbar fusion failed to show any benefit

over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. ([Brox, 2006](#)) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) ([Smeets, 2006](#)) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. ([Ivar Brox-Spine, 2003](#)) ([Fairbank-BMJ, 2005](#)) Cognitive behavioral therapy (CBT) significantly improves subacute and chronic low back pain both in the short term and during 1 year compared with advice alone and is highly cost-effective, a new RCT suggests. Disability scores as measured by the Roland Morris questionnaire improved by 2.4 points at the end of 12 months in the CBT group compared with 1.1 points among control patients. Patients were treated with up to 6 sessions of group CBT, whereas controls received no additional treatment other than a 15-minute session of active management advice. According to self-rated benefit from treatment, results showed that 59% of patients assigned to CBT reported recovery at 12 months compared with 31% of controls. Fear avoidance, pain self-efficacy, and the Short Form Health Survey physical scores also improved substantially in the CBT group but not in the control group. The CBT taught people how to challenge their fear of making things worse and to test out ways of improving their physical activity. ([Lamb, 2010](#)) See also Multi-disciplinary pain programs in the [Pain Chapter](#). See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter.

**ODG cognitive behavioral therapy (CBT) guidelines for low back problems:**

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks
- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

**ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:**

Screen for patients with risk factors for [delayed recovery](#), including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy](#) for [exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks
- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in [ODG Mental/Stress Chapter](#), repeated below.

**ODG Psychotherapy Guidelines:**

- Initial trial of 6 visits over 6 weeks
- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. ([Leichsenring, 2008](#))

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**